

**PENANG ADVENTIST HOSPITAL
465 BURMAH ROAD
10350 PENANG
MALAYSIA**

AUTHORIZATION TO RELEASE MEDICAL REPORT

Patient NRIC Name _____

Hospital Number: _____ NRIC/Passport Number: _____

Date of Birth: _____ Sex: _____

I authorized Penang Adventist Hospital to release my medical records/reports to the following person / agent / company / insurance company.

To _____

Name

Address

_____ Tel: _____

Fax: _____ e-mail: _____

Records requested: Discharge Documents X-ray Reports
 Medical Report Lab Reports
 Others _____

Period Covered: _____

SIGNATURE OF REQUESTOR / APPLICANT

Signed: _____ Date: _____
Patient/Parent/legal Representative/Spouse

Relationship to patient (if patient is not signing): _____ Witness: _____

Please indicate:

Patient is a Minor
 Patient is unable to sign

Name: _____

Date: _____